Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS3409HIC 05/07/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6376 DIAVIDSON COURT** TME RESIDENTIAL CARE LAS VEGAS, NV 89110 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) H 000 Initial Comments H 000 40C accepted
6/10/09 This Statement of Deficiencies was generated as a result of a State Licensure survey conducted in your facility on 05/07/09. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal. state or local laws. The census at the time of the survey was 1. Two resident files, one resident was hospitalized, and one employee file were reviewed. The following deficiencies were identified: H 019 Director Duties-No FA/CPR H₀₁₉ NAC 449.15523 Director: Duties. (NRS 449.249) The director of a home shall: 4. Ensure that a caregiver, who is capable of meeting the needs of the residents and has been trained in first aid, and cardiopulmonary resuscitation, is on the premises of the home at all times when a resident is present.

If deficiencies are cited, an approved plan of correction must be neturned within 10 days after receipt of this statement of deficiencies,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This Regulation is not met as evidenced by: Based on record review and staff interview on 05/07/09, the facility failed to ensure that 1 of 1

TITLE Director

STATE FORM

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

NVS3409HIC

B. WING

05/07/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

6376 DIAVIDSON COURT

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H 019	Continued From page 1 caregivers had received training in cardiopulmonary resuscitation (CPR) and fi (Employee #1). Findings include: The file of Employee #1, hire date 01/07/09 failed to contain a current CPR and first aid	9,	HO19 Employee #1 +OOK u CPR and first aid class at CPR connections, Lic on 6/3/09 copy of certification card enclosed.	
H 032	Safety & Sanitation-Fire Extinguisher NAC 449.15525 Requirements for safety ar sanitation of facility. (NRS 449.249) 2. A home must contain: (b) At least one functional, portable fire extinguisher; This Regulation is not met as evidenced by Based on observation on 05/07/09, the faci failed to have a label with the inspection dathe portable fire extinguisher. Findings include: The fire extinguisher had no inspection label it.	y: ility ate on	fire Extinguisher Inspection done by silver State Fire & Safety on 8/5/09. Label inspection date on portable fire extinguisher already attached. copy of inspection of inspection invoice / receipt enclosed.	
H 050	Tuberculosis-Employees NAC 441A.375 Medical facilities, facilities f dependent and homes for individual resider care: Management of cases and suspected cases; surveillance and testing of employee counseling and preventive treatment. 1. A case having tuberculosis or suspected considered to have tuberculosis in a medica facility or a facility for the dependent must be	ntial es; case al		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. HZRN11

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If continuation sheet 2 of 9



STATEMENT	OF DE	EFICIEN	CIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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05/07/2009

NAME OF PROVIDER OR SUPPLIER

TME RESIDENTIAL CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

6376 DIAVIDSON COURT LAS VEGAS, NV 89110

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H 050	managed in accordance with the guideline the Centers for Disease Control and Preve as adopted by reference in paragraph (h) subsection 1 of NAC 441A.200. 2. A medical facility, a facility for the depe or a home for individual residential care simaintain surveillance of employees of the or home for tuberculosis and tuberculosis infection. The surveillance of employees ronducted in accordance with the recommendations of the Centers for Disease Control and Prevention for preventing the transmission of tuberculosis in facilities prhealth care set forth in the guidelines of the Centers for Disease Control and Preventic adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 3. Before initial employment, a person eminal medical facility, a facility for the depe or a home for individual residential care shave a: (a) Physical examination or certification from licensed physician that the person is in a sigood health, is free from active tuberculos any other communicable disease in a constage; and (b) Tuberculosis screening test within the preceding 12 months, including persons we history of bacillus Calmette-Guerin (BCG) vaccination. If the employee has only completed the finof a 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test with the preceding 12 months, then the second of the 2-step Mantoux tuberculin skin test	ention of endent shall e facility must be ase e roviding he on as enployed endent shall endent			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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05/07/2009

Bureau of Health Care Quality & Compliance

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER

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6376 DIAVIDSON COURT LAS VEGAS, NV 89110

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H 050	physician determines that the risk of ex appropriate for a lesser frequency of text documents that determination. The risk exposure and corresponding frequency examination must be determined by fol guidelines of the Centers for Disease C Prevention as adopted by reference in (h) of subsection 1 of NAC 441A.200. 4. An employee with a documented hist positive tuberculosis screening test is expositive tuberculosis screening test administered radiographs unless he develops symptom suggestive of tuberculosis. 5. A person who demonstrates a positive tuberculosis screening test administered pursuant to subsection 3 shall submit to radiograph and medical evaluation for a tuberculosis. 6. Counseling and preventive treatment offered to a person with a positive tuber screening test in accordance with the grof the Centers for Disease Control and Prevention as adopted by reference in grof of subsection 1 of NAC 441A.200. 7. A medical facility shall maintain survey of employees for the development of pusymptoms. A person with a history of tuberculosis or a positive tuberculosis stest shall report promptly to the infection specialist, if any, or to the director or of tuberson in charge of the medical facility medical facility has not designated an in control specialist, when any pulmonary symptoms develop. If symptoms of tuber present, the employee shall be evaluated to NAC by Bd. of Health, eff. 1-23-28-96; R084-06, 7-14-2006)	sting and of of lowing the ontrol and paragraph cory of a exempt of a chest active the culosis uidelines paragraph eillance almonary creening in control ner if the infection erculosis uated for	H 050		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If continuation sheet 4 of 9



05/07/2009

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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A. BUILDING			
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H 050	Continued From page 4 This Regulation is not met as evidence	ed by:	H 050	H b 50 Employee # 1 TB Screening	
	Based on record review on 05/07/09, the failed to ensure that 1 of 1 caregiver cowith NAC 441A.375 regarding tubercula testing (Employee #1). Findings include:	e facility mplied		Employer # 1 TB Screening test and a physician statement to be held on 8/12/09.	
	The file of Employee #1, hire date 01/0 failed to contain a current TB screening a physician's statement.				
H 055	NAC 441A.380 Admission of persons to medical facilities, facilities for the dependence for individual residential care: To respiratory isolation; medical treatment counseling and preventive treatment; documentation. (NRS 441A.120) 1. Except as otherwise provided in this before admitting a person to a medical extended care, skilled nursing or intermicare, the staff of the facility shall ensure chest radiograph of the person has bee within 30 days preceding admission to the facility. 2. Except as otherwise provided in this the staff of a facility for the dependent, for individual residential care or a medifor extended care, skilled nursing or intermicare shall: (a) Before admitting a person to the facility has had a cough for more than 3 were staff of more than 3 were staff of more than 3 were staff of more than 3 were staff.	section, facility for lediate e that a n taken the section, a home cal facility ermediate	H 055		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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STATEMENT OF DEFICIENCIES
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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CO	NSTRUCTION
A. BUILDING	

(X3) DATE SURVEY COMPLETED

NVS3409HIC

B. WING

05/07/2009

NAME OF PROVIDER OR SUPPLIER

TMF RESIDENTIAL CARE

STREET ADDRESS, CITY, STATE, ZIP CODE

6376 DIAVIDSON COURT LAS VEGAS, NV 89110

PREFIX (EACH DEFICIENCY MUST BE PRECEDED 8)		LAS VEGAS, NV 89110			
		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORMAL Continued From page 5 (2) Has a cough which is productive; (3) Has blood in his sputum; (4) Has a fever which is not associated cold, flu or other apparent illness; (5) Is experiencing night sweats; (6) Is experiencing unexplained weight (7) Has been in close contact with a perhas active tuberculosis. (b) Within 24 hours after a person, incluperson with a history of bacillus Calmett (BCG) vaccination, is admitted to the fahome, ensure that the person has a tube screening test, unless there is not a perqualified to administer the test in the facility or home when the patient is admitted. If the a person qualified to administer the test facility or home when the person is admistaff of the facility or home shall ensure test is performed within 24 hours after a person arrives at the facility or home or days after the patient is admitted, which sooner. (c) If the person has only completed the of a two-step Mantoux tuberculin skin test or other single-step tuberculosis screening test. After a person an initial tuberculosis screening test. After a person had an initial tuberculosis screening test.	with a loss; or son who ding a te-Guerin cility or erculosis son cility or ere is not in the nitted, the that the qualified within 5 never is effect step est within sure that oux on has	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
	facility or home shall ensure that the pe a single tuberculosis screening test ann thereafter, unless the medical director of designee or another licensed physician determines that the risk of exposure is appropriate for a lesser frequency of test documents that determination. The risk exposure and corresponding frequency examination must be determined by foll guidelines as adopted by reference in pa	rson has ually or his sting and of of owing the			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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H 055	positive tuberculosi from skin testing an radiographs, but the shall ensure that the annually for the pre symptoms of tuberculous 4. If the staff of the that a person has have eks and that he is symptoms describe subsection 2, the perfacility or home if the respiratory isolation guidelines of the Control of subsection 1 control of subsection 2 control of subsection 2 control of subsection 2 control of subsection 3 control of subsectio	of NAC 441A.200. documented history is screening test is end routine annual characteristics and routine annual characteristics of the facility experson is evaluate exence or absence of culosis. facility or home detends one or more of the din paragraph (a) overson may be admitted in accordance with enters for Disease Cotted by reference in pof NAC 441A.200 urright determines whether	xempt est or home d at least f ermines than 3 he other f ed to the erson in the ontrol and baragraph ntil a er the	H 055			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

the staff shall not admit the person until a health care provider determines that the person does

5. If a test or evaluation indicates that a person has suspected or active tuberculosis, the staff of the facility or home shall not admit the person to the facility or home or, if he has already been admitted, shall not allow the person to remain in the facility or home, unless the facility or home keeps the person in respiratory isolation. The person must be kept in respiratory isolation until a health care provider determines that the person does not have active tuberculosis or certifies that, although the person has active tuberculosis, he is no longer infectious. A health care provider shall not certify that a person with active tuberculosis is not infectious unless the health care provider has obtained not less than

not have active tuberculosis.

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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) H 055 Continued From page 7 three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the pure of the facility or home shall ensure that counseling and prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that tay action carried out pursuant to this section and the results thereof are documented in the person 's medical record.	Bureau	of Health Care Quali	ity & Compliance					: 05/11/200 APPROVE
TIME RESIDENTIAL CARE (X4.)D. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) H 055 Continued From page 7 three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person 's medical record.	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		A. BUILDIN	G	COMPLE	ETED
AS VEGAS, NV 89110 CALL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY REPLIAN OF CORRECTION SHOULD BE EACH CORRECTIVE ACTION SHOULD BE COMMITTED COMMITTED	NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
## REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE ## 1055 Continued From page 7 H 055 ## 1055 Continued From page 7 H 055 ## 1056 Three consecutive negative sputum AFIB smears which were collected on separate days. ## 1056 If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. ## 1056 T	TME RES	SIDENTIAL CARE						
three consecutive negative sputum AFIB smears which were collected on separate days. 6. If a test indicates that a person who has been or will be admitted to a facility or home has active tuberculosis, the staff of the facility or home shall ensure that the person is treated for the disease in accordance with the recommendations of the Centers for Disease Control and Prevention for the counseling of, and effective treatment for, a person having active tuberculosis. The recommendations are set forth in the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (g) of subsection 1 of NAC 441A.200. 7. The staff of the facility or home shall ensure that counseling and preventive treatment are offered to each person with a positive tuberculosis screening test in accordance with the guidelines of the Centers for Disease Control and Prevention as adopted by reference in paragraph (h) of subsection 1 of NAC 441A.200. 8. The staff of the facility or home shall ensure that any action carried out pursuant to this section and the results thereof are documented in the person's medical record.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
(Added to NAC by Bd. of Health, eff. 1-24-92; A 3-28-96; R084-06, 7-14-2006)	H 055	three consecutive respective to the disease in accorrection and Preventing the guidelines of Control and Preventing paragraph (g) of 441A.200. 7. The staff of the fithat counseling and offered to each pertuberculosis screenthe guidelines of the fithat any action carrisection and the resin the person's me (Added to NAC by	negative sputum AFI ed on separate days, is that a person who I to a facility or home , the staff of the facil that the person is tre ordance with the of the Centers for Di ntion for the counseli for, a person having ecommendations are if the Centers for Dise ordance with the commendations are if the Centers for Dise ordance with a positive nition as adopted by re accility or home shall depreventive treatme reson with a positive ning test in accordance adopted by reference adopted by reference adopted by reference adopted out pursuant to the cults thereof are docu- dedical record. Bd. of Health, eff. 1-	nas been has lity or eated for sease ang of, and active e set forth ease reference ce with se Control e in 41A.200. ensure this umented	H 055			

This Regulation is not met as evidenced by: Based on record review on 05/07/09, the facility failed to ensure that 1 of 2 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #2).

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies. HZRN11

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If continuation sheet 8 of 9

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STATEMENT OF DEFICIENCIES	
AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION			
A. BUILDING	1.4		

(X3) DATE SURVEY COMPLETED

NVS3409HIC

B. WING

05/07/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

TME RESIDENTIAL CARE

6376 DIAVIDSON COURT LAS VEGAS, NV 89110

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H 055	Continued From page 8	+	H 055	u n c c	
	Findings include:			H 0 5 5	
	Resident #2's file failed to include a curre screening test.	ent TB	·	Resident #2 step 1 TB test done on 6/3/09	
				at southwest Medical	
				MIJACIAI	
				from Home Health read I week from the date given will be on \$110/09 2nd placed on 10th read on the	
	92			date given will be on	
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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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